House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

by deleting all of the language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Sections 56-32-210 and 56-32-227 are amended by deleting such sections in their entirety.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 6, Part 7 is amended by deleting the part in its entirety and substituting instead the language of Section 9 of this act as a new Part 7.

SECTION 3. The title of this act is, and may be cited as, the "Managed Care Accountability Act".

SECTION 4. It is the intent of the general assembly to provide a mechanism to regulate a mandated minimal quality level and standard of medical care provided for conditions covered by managed care entities.

SECTION 5. Tennessee Code Annotated, Title 29, is amended by adding Sections 6 through 8 of this act as a new, appropriately designated chapter.

SECTION 6. As used in this act:

(1) “Adverse determination” means a determination by a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary.

(2) "Appropriate and medically necessary" means the recognized standard of

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

acceptable healthcare services as determined by healthcare providers in accordance with the prevailing practices and standards of the medical profession and community.

(3) “Business day” means a weekday, excluding a legal holiday.

(4) "Commissioner" means the commissioner of commerce and insurance;

(5) “Emergency care” means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that such person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) placing the patient’s health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(6) "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents;

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(7) "Healthcare plan" means any plan whereby any person or entity undertakes to provide, arrange for, pay for or reimburse any part of the cost of any healthcare services.

(8) "Healthcare provider" means any person or entity performing services regulated pursuant to Tennessee Code Annotated, Title 63 or Title 68, Chapter 11.

(9) "Healthcare treatment decision" means a determination as to when medical services are actually provided by the healthcare plan or a decision which affects the quality of diagnosis, care or treatment provided to enrollees of the healthcare plan.

(10) "Health insurer" means an authorized insurance company that issues policies of accident and sickness insurance.

(11) "Health maintenance organization" means an entity regulated pursuant to Tennessee Code Annotated, Title 56, Chapter 32, Part 2.

(12) “Life threatening” means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(13) "Managed care entity" means a health insurer, health maintenance organization or any other entity that delivers, administers or assumes risk for healthcare services with systems or techniques to control or influence the quality, accessibility, utilization or costs and prices of such services to a defined enrollee population.

(14) "Ordinary and reasonable care" means the recognized standard of acceptable care that a managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a managed care entity, "ordinary and reasonable

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

care" means the recognized standard of acceptable care that a person of ordinary prudence in the same profession, specialty or area of practice would use in the same or similar circumstances.

(15) “Patient” means the enrollee or an eligible dependent of the enrollee under a healthcare plan or health insurance plan.

(16) “Provider of record” means the physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the enrollee and includes any health care facility when treatment is rendered on an inpatient or outpatient basis.

(17)(A) "Utilization review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an individual within this state;

(B) "Utilization review" does not include elective requests for clarification of coverage;

(18) "Utilization review agent" means any person or entity, including the state of Tennessee, performing utilization review, except:

(A) This article shall not apply to a person who provides information to enrollees about scope of coverage or benefits provided under a health insurance policy or healthcare plan and who does not determine whether particular health care services provided or to be provided to an enrollee are medically necessary or appropriate.

(B) An agency of the federal government;

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(C) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government;

(D) A hospital's internal quality assurance program;

(E) An employee of a utilization review agent.

SECTION 7.

(a) A managed care entity has the duty to exercise ordinary and reasonable care when making healthcare treatment decisions and is liable for damages for an enrollee's harm proximately caused by the managed care entity's failure to exercise such ordinary and reasonable care.

(b) A managed care entity is also liable for damages for an enrollee's harm proximately caused by the healthcare treatment decisions made by the entity's:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives;

who are acting on the entity's behalf and over whom the entity has the right to exercise influence or control or has actually exercised influence or control, which result in the failure to exercise ordinary and reasonable care.

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(c) It shall be a defense to any action brought, pursuant to this act, against a managed care entity that:

(1) Neither the managed care entity nor its employees, agents, ostensible agents or representatives controlled, influenced or participated in the healthcare treatment decision; and

(2) The managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the enrollee.

(d) The provisions of this act may not be construed to impose an obligation on the managed care entity to provide to an enrollee any treatment that is not covered by the healthcare plan.

(e) The provisions of this act may not be construed to impose liability on:

(1) an employer, an employer group purchasing organization, or a pharmacy licensed by the state board of pharmacy that purchases coverage or assumes risk on behalf of its employees;

(2) an employer of an enrollee or that employer's employees, unless the employer is the enrollee's managed care entity; or

(3) an employee organization, a voluntary employee beneficiary organization, or a similar organization, unless such organization is the enrollee's

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

managed care entity and makes healthcare treatment decisions under a healthcare plan.

(f) A managed care entity may not remove a healthcare provider from its plan or refuse to renew the healthcare provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary healthcare for the enrollee.

(g) In an action brought pursuant to this act, no provision of statute or rule, prohibiting a managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense.

(h) In an action brought pursuant to this act, a finding that a healthcare provider is an employee, agent, ostensible agent, or representative of a managed care entity may not be based solely on proof that the name of such provider appears in a listing of approved healthcare providers made available to enrollees under a healthcare plan.

(i) The provisions of this act do not apply to workers' compensation insurance coverage as set forth in Tennessee Code Annotated, Title 50, Chapter 6.

SECTION 8.

(a) A person may maintain a cause of action under this act when, except for circumstances described in section (f), the affected enrollee or the enrollee's representative:

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(1) Has exhausted utilization review, appeal, and independent review procedures as established by Section 9 of this act; or, alternatively,

(2) Before bringing the action:

(A) Gives written notice of the claim in accordance with the requirements of subsection (b); and

(B) Agrees to submit the claim for mediation or other nonbinding alternative dispute resolution.

(b) The notice required by subsection (a)(2)(A) must be delivered to the managed care entity at least thirty (30) days prior to filing a cause of action pursuant to this act.

(c) If, within fourteen (14) days of receiving such notice, the managed care entity requests mediation or other nonbinding alternative dispute resolution, then the enrollee or the enrollee's representative must submit the claim for such mediation or dispute resolution. However, if the managed care entity does not timely request such mediation or dispute resolution, then the enrollee or the enrollee's representative may proceed to file the cause of action following expiration of the thirty (30) day period required by subsection (b).

(d) If the enrollee or the enrollee's representative does not comply with subsection (a) prior to filing an action pursuant to this act, then such action shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

the review and appeal procedures required by subsection (a)(1) or, alternatively, to mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed thirty (30) days for such purposes. Such orders of the court shall be the sole remedy available to a managed care entity complaining of noncompliance with subsection (a).

(e) If the enrollee or the enrollee's representative seeks to exhaust the review and appeal procedures required by subsection (a)(1) or provides notice, pursuant to subsection (a)(2)(A), before the statute of limitations applicable to a claim against a managed care entity has expired, then the limitations period shall not expire prior to:

(1) The thirtieth day following exhaustion of such review and appeal procedures;

(2) The thirtieth day following completion of mediation or other nonbinding alternative dispute resolution requested by the managed care entity; or

(3) In the absence of review and appeal procedures as required by (a)(1), mediation or other nonbinding alternative dispute resolution, the forty-fourth day following the date on which the enrollee or the enrollee's representative gives notice under subsection (a)(2)(A).

(f) The provisions of this act may not be construed to prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting procedures for utilization

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

review or independent review places the enrollee's health in serious jeopardy or irreparable harm.

SECTION 9. Tennessee Code Annotated, Title 56, Chapter 6 is amended by adding Part 7 to read as follows:

56-6-701. Short Title. - The title of this part is, and may be cited as, the "Health Care Service Utilization Review Act."

56-6-702. Purpose. - The purpose of this part is to:

(1) Foster greater coordination and cooperation between health care providers and utilization review agents;

(2) Ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable laws.

56-6-703. Definitions. - As used in this part, unless the context otherwise requires:

(1) “Adverse determination” means a determination by a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary.

(2) "Appropriate and medically necessary" means the recognized standard of acceptable healthcare services as determined by healthcare

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

providers in accordance with the prevailing practices and standards of the medical profession and community.

(3) “Business day” means a weekday, excluding a legal holiday.

(4) "Commissioner" means the commissioner of commerce and insurance;

(5) “Emergency care” means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that such person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) placing the patient’s health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(6) "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents;

(7) "Healthcare plan" means any plan whereby any person or entity undertakes to provide, arrange for, pay for or reimburse any part of the cost of any healthcare services.

(8) "Healthcare provider" means any person or entity performing services regulated pursuant to Tennessee Code Annotated, Title 63 or Title 68, Chapter 11.

(9) "Healthcare treatment decision" means a determination as to when medical services are actually provided by the healthcare plan or a decision which affects the quality of diagnosis, care or treatment provided to enrollees of the healthcare plan.

(10) "Health insurer" means an authorized insurance company that issues policies of accident and sickness insurance.

(11) "Health maintenance organization" means an entity regulated pursuant to Tennessee Code Annotated, Title 56, Chapter 32, Part 2.

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(12) “Life threatening” means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(13) "Managed care entity" means a health insurer, health maintenance organization or any other entity that delivers, administers or assumes risk for healthcare services with systems or techniques to control or influence the quality, accessibility, utilization or costs and prices of such services to a defined enrollee population.

(14) "Ordinary and reasonable care" means the recognized standard of acceptable care that a managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a managed care entity, "ordinary and reasonable care" means the recognized standard of acceptable care that a person of ordinary prudence in the same profession, specialty or area of practice would use in the same or similar circumstances.

(15) “Patient” means the enrollee or an eligible dependent of the enrollee under a healthcare plan or health insurance plan.

(16) “Provider of record” means the physician or other health care provider that has primary responsibility for the care, treatment, and services

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

rendered to the enrollee and includes any health care facility when treatment is rendered on an inpatient or outpatient basis.

(17)(A) "Utilization review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an individual within this state;

(B) "Utilization review" does not include elective requests for clarification of coverage;

(18) "Utilization review agent" means any person or entity, including the state of Tennessee, performing utilization review, except:

(A) An agency of the federal government;

(B) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government;

(C) A hospital's internal quality assurance program;

(D) An employee of a utilization review agent.

56-6-704. Utilization Review Agents

(a) Utilization review agents shall adhere to the minimum review standards set forth in § 56-6-705.

(b) On or after July 1, 1993, a utilization review agent may

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

not conduct utilization review in this state unless the utilization review agent has certified to the commissioner in writing that the agent is in compliance with § 56-6-705. Certification shall be made annually on or before July 1 of each calendar year. In addition, a utilization review agent shall file the following information:

(1) The name, address, telephone number, and normal business hours of the utilization review agent;

(2) The name and telephone number of a person for the commissioner to contact; and

(3) A description of the appeal procedures for utilization review determinations.

Any material changes in the information filed in accordance with this section shall be filed with the commissioner within thirty (30) days of the change.

(c) Upon filing the certification, each utilization review agent shall pay an annual fee in the amount of one thousand dollars ($1,000) to the department. The commissioner shall exempt from payment of the annual fee any utilization review agent which has received accreditation by the utilization review accreditation commission (URAC). All fees paid to the department under this part shall be held by the commissioner as expendable receipts for the purpose of administering the provisions of this part.

56-6-705. Standards for Utilization Review.

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(a) The utilization review plan, including reconsideration and appeal requirements, shall be reviewed by a physician and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician.

(b) A utilization review agent shall not set or impose any notice or other review procedures contrary to the requirements of the health insurance policy or healthcare plan.

(c) A utilization review agent must not have previously participated in the care or treatment of the patient. Unless approved for an individual patient by the provider of record or modified by contract, a utilization review agent shall be prohibited from observing, participating in, or otherwise being present during a patient's examination, treatment, procedure, or therapy. In no event shall this section otherwise be construed to limit or deny contact with a patient for purposes of conducting utilization review unless otherwise specifically prohibited by law.

(d) A utilization review agent may not permit or provide compensation or any thing of value to its employees or agents, condition employment of its employee or agent evaluations, or set its employee or agent performance standards, based on the amount of volume of adverse determinations, reductions or limitations on lengths of stay, benefits, services, or charges or on the number or frequency of telephone calls or other contacts with healthcare providers or patients, which are inconsistent with the provisions of this act.

(e) A healthcare provider may designate one or more individuals as the initial

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

contact or contacts for utilization review agents seeking routine information or data. In no event shall the designation of such an individual or individuals preclude a utilization review agent or medical advisor from contacting a healthcare provider or others in his or her employ where a review might otherwise be unreasonably delayed or where the designated individual is unable to provide the necessary information or data requested by the utilization review agent.

(f) Utilization review conducted by a utilization review agent shall be under the direction of a physician licensed to practice medicine by a state licensing agency in the United States.

(g) Each utilization review agent shall utilize written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other healthcare providers. Utilization review decisions shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis. Screening criteria must be used to determine only whether to approve the requested treatment. Denials must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity. Such written screening criteria and review procedures shall be available for review and inspection to determine

appropriateness and compliance as deemed necessary by the commissioner and copying as necessary for the commissioner to carry out such commissioner's lawful duties under this act, provided, however, that any information obtained or acquired under the authority of this subsection and act is confidential and privileged and not subject to the open records law or subpoena except to the extent necessary for the commissioner to enforce this act.

(h) A utilization review agent may not engage in unnecessary or unreasonable repetitive contacts with the health care provider or patient and shall base the frequency of contacts or reviews on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(i) Subject to the notice requirements of §56-6-706 of this act, in any instance where the utilization review agent is questioning the medical necessity or appropriateness of health care services, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the utilization review agent's decision with a physician prior to issuance of an adverse determination.

(j) Unless precluded or modified by contract, a utilization review agent shall reimburse health care providers for the reasonable costs for providing medical information in writing, including copying and transmitting any requested patient records or other documents. A health care provider's charges for providing medical information to a utilization review agent shall not exceed the cost of copying set by Tennessee Code Annotated, Section 63-2-102, for records and may not include any costs that are

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

otherwise recouped as a part of the charge for health care.

(k) A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review and shall maintain records of such complaints for three (3) years from the time the complaints are filed. The complaint procedure shall include a written response to the complainant by the agent within thirty (30) days. The utilization review agent shall permit the commissioner to examine the complaints and all relevant documents at any time.

(l) The utilization review agent may delegate utilization review to qualified personnel in the hospital or health care facility where the health care services were or are to be provided. However, such delegation shall not relieve the utilization review agent of full responsibility for compliance with this act, including the conduct of those to whom utilization review has been delegated.

(m) Utilization review agents shall make staff available by toll-free telephone at least forty (40) hours per week during normal business hours;

(n) Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to these calls within two (2) working days;

(o) Utilization review agents shall comply with all applicable laws to protect the confidentiality of individual medical records;

(p) Physicians or psychologists making utilization review determinations shall have current licenses from a state licensing agency in the United States;

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(q) Utilization review agents shall allow a minimum of twenty-four (24) hours after an emergency admission, service, or procedure for an enrollee or the enrollee's representative to notify the utilization review agent and request certification or continuing treatment for that condition;

(r) The commissioner shall exempt from these standards any utilization review agent that has received accreditation by the utilization review accreditation commission; and

(s) A utilization review agent must provide a written description to the commissioner setting forth the procedures to be used when responding to poststabilization care subsequent to emergency treatment as requested by a treating physician or health care provider.

56-6-706. Notice of determinations made by utilization review agents.

(a) Notification of a determination by the utilization review agent shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two (2) business days of the receipt of the request for determination and the receipt of all information necessary to complete the review;

(b) In the event of an adverse determination, the notification by the utilization review agent must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description or the source of the screening criteria that were utilized as guidelines in making the determination; and

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(4) a description of the procedure for the complaint and appeal process, including:

(A) notification to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization;

(B) notification to the enrollee of the procedures for appealing an adverse determination to an independent review organization; and

(C) notification to an enrollee who has a life-threatening condition of the enrollee's right to an immediate review by an independent review organization and the procedures to obtain that review.

(c) The notification of adverse determination required by this section shall be provided by the utilization review agent:

(1) within one (1) working day by telephone or electronic transmission to the provider of record in the case of a patient who is hospitalized at the time of the adverse determination, to be followed by a letter notifying the patient and the provider of record of an adverse determination within three (3) working days;

(2) within three (3) working days in writing to the provider of record and the patient if the patient is not hospitalized at the time of the adverse determination; or

(3) within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from notification when denying poststabilization care subsequent to emergency treatment as requested by a treating physician or provider. In such

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

circumstances, notification shall be provided to the treating physician or health care provider.

56-6-707. Appeal of adverse determinations of utilization review agents

(a) A utilization review agent shall maintain and make available a written description of appeal procedures involving an adverse determination. For the purposes of this section, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination.

(b) The procedures for appeals must be reasonable and must include the following:

(1) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the adverse determination orally or in writing;

(2) a provision that, within five (5) working days from receipt of the appeal, the utilization review agent shall send to the appealing party a letter acknowledging the date of the utilization review agent's receipt of the appeal. The letter must also include the provisions listed in this subsection and a list of the documents that the appealing party must submit for review by the utilization review agent. When the utilization review agent receives an oral appeal of adverse determination, the utilization review agent shall send a one-page appeal form to the appealing party;

(3) a provision that appeal decisions shall be made by a physician, provided that, if the appeal is denied and within ten (10) working days the

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the adverse determination, and that specialty review shall be completed within fifteen (15) working days of receipt of the request;

(4) in addition to the written appeal, a method for an expedited appeal procedure for emergency care denials and denials of continued stays for hospitalized patients. That procedure must include a review by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review. The time frame in which the appeal must be completed shall be based on the medical immediacy of the condition, procedure, or treatment, but may not exceed one (1) working day from the date all information necessary to complete the appeal is received;

(5) a provision that after the utilization review agent has sought review of the appeal of the adverse determination, the utilization review agent shall issue a response letter to the patient or a person acting on behalf of the patient, and the patient's physician or health care provider, explaining the resolution of the appeal; and

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(6) written notification to the appealing party of the determination of the appeal, as soon as practical, but in no case later than the thirtieth calendar day after the date the utilization agent receives the appeal. If the appeal is denied, the written notification shall include a clear and concise statement of:

(A) the clinical basis for the appeal's denial;

(B) the specialty of the physician or other health care provider making the denial; and

(C) notice of the appealing party's right to seek review of the denial by an independent review organization under §56-6-708 of this act and the procedures for obtaining that review.

(c) Notwithstanding this act or any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an independent review organization as provided by §56-6-708 of this act and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

56-6-708. Independent review of adverse determinations

(a) A utilization review agent shall:

(1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with §56-6-709 of this chapter;

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(2) provide to the appropriate independent review organization not later than the third business day after the date that the utilization review agent receives a request for review a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed by the organization;

(C) the written notification described by 56-6-707(b)(5) and (6) of this act;

(D) any documentation and written information submitted to the utilization review agent in support of the appeal; and

(E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;

(3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and

(4) The enrollee shall be required to pay a one-time fee of twenty-five dollars ($25.00) toward the cost of the independent review, payable at the time the enrollee requests the independent review.

(b) Confidentiality

(1) A utilization review agent shall preserve the confidentiality of

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

individual medical records to the extent required by law.

(2) A utilization review agent may not disclose or publish individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the prior written consent of the patient or as otherwise required by law. If such authorization is submitted by anyone other than the individual who is the subject of the personal or confidential information requested, such authorization must:

(A) be dated; and

(B) contain the signature of the individual who is the subject of the personal or confidential information requested. The signature must have been obtained one (1) year or less prior to the date the disclosure is sought or the authorization is invalid.

(C) A utilization review agent may provide confidential information to a third party under contract or affiliated with the utilization review agent for the sole purpose of performing or assisting with utilization review. Information provided to third parties shall remain confidential.

(D) If an individual submits a written request to the utilization review agent for access to recorded personal information about the individual, the utilization review agent shall within ten (10) business days from the date such request is received:

(i) inform the individual submitting the request of the nature and

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

substance of the recorded personal information in writing; and

(ii) permit the individual to see and copy, in person, the recorded personal information pertaining to the individual or to obtain a copy of the recorded personal information by mail, at the discretion of the individual, unless the recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing.

(E) A utilization review agent's charges for providing a copy of recorded personal information to individuals shall be reasonable, as determined by rule of the commissioner, and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(F) Confidential information in the custody of a utilization review agent may be provided to an independent review organization, subject to rules and standards adopted by the commissioner.

(G) The utilization review agent may not publish data which identifies a particular physician or health care provider, including any quality review studies or performance tracking data, without prior written notice to the involved provider. This prohibition does not apply to internal systems or reports used by the utilization review agent.

(H) Documents in the custody of the utilization review agent that contain confidential patient information or physician or health care provider financial data shall be destroyed by a method which induces complete destruction of the information when the agent determines the information is no longer needed.

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(I) All patient, physician, and health care provider data shall be maintained by the utilization review agent in a confidential manner which prevents unauthorized disclosure to third parties. Nothing in this act shall be construed to allow a utilization review agent to take actions that violate a state or federal statute or regulation concerning confidentiality of patient records.

(J) Notwithstanding the provisions in subdivisions (A) through (I) of this section, the utilization review agent shall provide to the commissioner on request individual medical records or other confidential information for determination of compliance with this article. The information is confidential and privileged and is not subject to the public records law, or to subpoena, except to the extent necessary to enable the commissioner to enforce this act.

56-6-709. Independent review process

(a) Every health care plan (hereafter referred to as "plan") shall provide an independent review process to examine the plan's decisions pertaining to medical necessity for individual enrollees:

(1) The enrollee has received an adverse utilization review determination of a healthcare treatment decision;

(2) The enrollee is a member of the plan in good standing, and is otherwise eligible to receive covered benefits under the health plan;

(3) The enrollee has complied with the utilization review procedures described in this Part.

(b) The standards for independent review required by subsection (a) of this

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

section shall ensure:

(1) the timely response of an independent review organization selected under this Part;

(2) the confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(3) the qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making the determinations; and

(5) timely notice to enrollees of the results of the independent review, including the clinical basis for the determination.

(c) The standards adopted under subsection (a) of this section must include standards that require each independent review organization to make its determination:

(1) not later than the earlier of:

(A) the fifteenth day after the date the independent review organization receives the information necessary to make the determination; or

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(B) the twentieth day after the date the independent review organization receives the request that the determination be made; and

(2) in the case of a life-threatening condition, not later than the earlier of:

(A) the fifth day after the date the independent review organization receives the information necessary to make the determination; or

(B) the eighth day after the date the independent review organization receives the request that the determination be made.

(d) An independent review organization must annually submit to the commissioner the following:

(1) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent (5%) of any stock or options;

(2) the name of any holder of bonds or notes of the applicant that exceed one hundred thousand dollars ($100,000);

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under subdivision (3) and a description of any relationship the named individual has with:

(A) a healthcare plan;

(B) health insurer ;

(C) a utilization review agent;

(D) a healthcare provider; or

(E) a group representing any of the entities described by subparts (A) through (D) of this subdivision;

(5) the procedures to be used by the independent review organization in making review determinations with respect to reviews conducted under §56-6-708.

(e) An independent review organization may not be a subsidiary of, or in any way owned or controlled by a trade or professional association of health insurers.

(f) An independent review organization conducting a review under 56-6-708 is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

(g) If at any time there is a material change in the information included under subsection (d) of this section, the independent review organization shall submit updated information to the commissioner.

56-6-710. Violations

(a) Whenever the commissioner has reason to believe that a utilization review agent subject to this part has been or is engaged in conduct that violates this part, the commissioner shall notify the utilization review agent of the alleged violation. The utilization review agent has thirty (30) days from the date the notice is received to respond to the alleged violation.

(b) If the commissioner believes the utilization review agent has violated this part, or is not satisfied that the alleged violation has been corrected, the commissioner may conduct a contested case hearing on the alleged violation in accordance with the Uniform Administrative Procedures Act, compiled in Title 4, chapter 5.

(c) If, after the hearing, the commissioner determines that the utilization review agent has engaged in violations of this part, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the utilization review agent a copy of the findings and an order requiring the utilization review agent to cease and desist from engaging in the violations. The commissioner may also, at the commissioner's discretion, order:

(1) Payment of a penalty of not more than ten thousand dollars ($10,000) in the aggregate for a violation that occurred with such frequency as to indicate a

House Judiciary Committee Amendment #1

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to HB1466

Buck
Signature of Sponsor

AMEND Senate Bill No. 20* House Bill No. 1466

general business pattern or practice; or

(2) Suspension or revocation of the authority to do business in this state as a utilization review agent if the utilization review agent knew the act was in violation of this chapter and repeated the act with such frequency as to indicate a general business pattern or practice.

56-6-711. Authority to adopt rules.

The commissioner may have the authority to adopt rules and regulations to implement the provisions of this part.

SECTION 10. The office of the comptroller shall study the fiscal impact of this Act one (1) year after the effective date. Upon a finding of minimal impact, this Act shall automatically apply to the employees of the state of Tennessee.

SECTION 11. The provisions of this act do not apply to TennCare.

SECTION 12. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 13. This act shall take effect July 1, 2001, the public welfare requiring it.